9% of total cost of T2DM. The cost estimate was most sensitive to incidence and event cost of peripheral vascular disease, stroke and severe vision loss. **CONCLUSIONS:** Based on the present analysis, T2DM places a significant financial burden on the health care system in Mexico, with cost of treating related complications being the main cost driver. Given the model focuses on diagnosed and treated T2DM patients, it is likely this cost is even higher when undiagnosed and untreated patients are considered. Delaying the onset of complications could result in a reduction in costs, as well as benefits for the patient and health care system.

PDB7

DIRECT COSTS OF TYPE 2 DIABETES FROM THE BRAZILIAN PUBLIC HEALTH CARE SECTOR PERSPECTIVE

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OBJECTIVES: This study aimed to quantify the annual financial cost of type 2 diabetes (T2DM) in Brazil and explore the relative contribution of different components of cost. **METHODS:** A cost of illness model was developed in Microsoft Excel 2007 to estimate the financial cost of T2DM in Brazil from the public health care payer perspective. Cost of routine management and complications were included in the analysis. Data inputs for prevalence of T2DM (weighted to include only patients who are diagnosed and treated) and related complications, costs and routine management were sourced from the published literature and publicly available databases, where available. Key opinion leader input was sought to fill data gaps. Sensitivity analyses were conducted to identify parameters which were most likely to impact overall results when varied. Costs are presented in Brazilian Reals 2012. **RESULTS:** The annual cost of T2DM in Brazil is estimated to be 11,275,921,167 BRL ($5,471,123,022USD) which represents 5.3% of national health care expenditure. Costs of complications were estimated to account for 56% of the total cost of T2DM. Cardiovascular complications accounted for 32% of total T2DM cost. Diabetes drug costs were estimated to account for 31% of total T2DM health care spending. The overall cost estimate was most sensitive to the laser eye surgery, hemodialysis and cardiovascular complications and the frequency and cost of routine physician consultations. **CONCLUSIONS:** The findings indicate that there is a high economic burden of T2DM for the Brazilian health care system. Cost of treating related complications was the main driver. An even higher burden of the disease is expected if undiagnosed and patients currently not being treated start receiving public medical attention. The burden of the disease could considerably be reduced if T2DM related complications were avoided, which not only benefits the health care system but the patients as well.

PDB8

TRENDS IN HEALTH CARE RESOURCES UTILIZATION, COST AND MEDICATION SELECTION IN THE TREATMENT OF DIABETES

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OBJECTIVES: Diabetes is one of the most common chronic diseases in Canada. It affects about 6.8% of the Canadian population. Treating and managing the disease and its complications is associated with a significant economic burden. The objective of this study was to analyse trends in terms resource utilization, cost and treatment patterns in the management of diabetes. **METHODS:** Patients covered by the Quebec provincial drug reimbursement program (RAMQ) who had a diagnosis of diabetes, in 2005 and were covered continuously by the public drug program for the period from January 2006 to December 2010 were selected. Health care resources in terms of diabetes medications and physician visits, hospitalization, intensive care unit stay, hospital outpatient clinic visits, and emergency room visits associated with a diagnosis of diabetes were estimated over a 5-year period, from January 2006 to December 2010. Trends in the proportion of diabetes medications used each year over the 5-year study period were also estimated. **RESULTS:** A total of 46,194 diabetic patients were included in the study. The mean age of the study population was 65.4 years (SD=12.3) and proportion of male/female was 47% and 53% respectively. Over the study period, annual cost of diabetes medications varied from $320 (SD=464) in 2006 to $372 (SD=546) in 2010 (+16%) while total cost of treatment associated with diabetes varied from $627 (SD=1456) to $715 (SD=1632) (+14%) during that period. Metformine remains the most widely used medication throughout the study period with 64.3% of users in 2006 and 65.6% in 2010. Proportion of insulin users increased from 15.2% to 22.7% while gliclazide users increased from 4.4% to 11.2% during the study period. **CONCLUSIONS:** Over the five-year study period cost of diabetes treatment has increased at a rate similar to inflation, while trends of increased adoption of insulin and newer medications is observed.

PDB9

COST-EFFECTIVENESS OF PARICALCITOL VERSUS PARATHYROIDECTOMY FOR SECONDARY HYPERPARATHYROIDISM TO CHRONIC KIDNEY DISEASE IN MEXICO

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OBJECTIVES: Secondary hyperparathyroidism (SHPT) affects one of every two Mexicans with chronic kidney disease (CKD) at stage five. The objective of this research was to assess cost effectiveness (CE) of Paricalcitol intravenous administration (IV) versus parathyroidectomy (PTX) from Mexican payer perspective. **METHODS:** A decision tree model was designed to simulate patient resources usage and survival rate in 5 years time-frame treated with paricalcitol IV and parathyroidectomy based on clinical data in recent published literature. Time-frame begins when a patient is refractory to Calcitriol therapy and physician decides to treat with Paricalcitol or program PTX. Resources usage considered were just directly related to SHPT treatment: drug cost, surgery and hospitalization costs and medical supplies linked. Unit costs were collected from Mexican Government Databases: IMSS official database, Diagnosis Related Groups from IMSS, Official Journal of the Federation. (Cost considered 5% annual discount rate).Incremental Cost-Effectiveness Ratio (ICER) was calculated with treatment costs and Life-years gained (LYG) offset based on incremental survival rate of compared therapies. Probabilistic Multivariable sensibility analysis was completed with 5,000 simulated patients. **RESULTS:** Survival rate and confidence interval obtained from model was 0.63 (0.60, 0.66) for paricalcitol and 0.46 (0.44, 0.48) for PTX. Average survival of both therapies resulted in an incremental 0.61 LYG for paricalcitol patients (+18%). Average five years treatment cost for Paricalcitol patients was $10,024.25, while PTX was US$5,369.74(-46%) resulting in an ICER of US$7,619.94 per LYG, which is 28.2% below Mexican Gross Domestic Product (GDP) per capita. Probabilistic analysis shown: 90.1% of patient treated had a cost-effective outcome and 7.2% of cases had a dominant outcome. **CONCLUSIONS:** According to results obtained and using a threshold of US$29,306.29 (3 x GDP per capita), Paricalcitol is a highly cost-effective treatment option compared to PTX when treating patients with SHPT at IMSS.

PDB10

COST-EFFECTIVENESS OF FIXED-DOSE COMBINATION (FDC) OF VILDAGLIPTIN/METFORMIN FOR THE TREATMENT OF DIABETES MELLITUS TYPE 2 IN MEXICO

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OBJECTIVES: Type 2 Diabetes is a major public health care problem in Mexico. Some patients may require more than one oral antidiabetic treatment to achieve glycemic control. Vildagliptin, a DPPIV inhibitor is an option in combination with the standard treatment of metformin. The objective was to assess the cost-effectiveness of Vildagliptin/Metformin FDC versus other oral treatments available in the public market. **METHODS:** Cost-effectiveness analysis of the oral antidiabetic treatments available in the public market in Mexico was conducted. The comparisons included the following options: Vildagliptin/Metformin FDC, glibenclamide, and thiazolidinediones (Rosiglitazone and pioglitazone). Cost effectiveness analysis versus other oral antidiabetics incorporated the incidence and costs of adverse events according to Ferrannini 2009 and Gonzalez-Ortíz 2009 for glibenclamide and Motola 2012 for thiazolidinediones. Drug costs were elicited from public tenders and health care services from unitary costs of the IMSS. The perspective is the public health provider and the time horizon is one year. **RESULTS:** The use of Vildagliptin/Metformin FDC (50/500 or 850 mg) BID compared to glibenclamide, is a dominant strategy if the cost per hypoglycemia exceeds US$714.03. Vildagliptin/Metformin FDC is dominant versus pioglitazone,if the cost of fractures incurred by pioglitazone exceeds US$56.56. Drug acquisition costs of Vildagliptin/Metformin FDC are 150% cheaper per patient treated vs rosiglitazone; additionally rosiglitazone is associated with myocardial infarction events. **CONCLUSIONS:** Vildagliptin/Metformin FDC is an opportunity for resource optimization in the public sector. This cost effectiveness analysis is not considering other potential adherence benefits which are related with having two treatments in one pill.

PDB11

PROBABILISTIC SENSITIVITY ANALYSIS TO ANALYZE THE COST-EFFECTIVENESS OF ORAL HYPOGLYCEMIC AGENTS IN THE INITIAL ORAL DRUG TREATMENT OF OUTPATIENTS DIAGNOSED WITH TYPE 2 DIABETES IN PRIMARY CARE

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OBJECTIVES: To perform a probabilistic sensitivity analysis to analyze previously reported results about the cost-effectiveness of oral hypoglycemic agents (OHA's) in the initial oral drug treatment of patients diagnosed with type 2 diabetes mellitus in public primary attention in Mexico. **METHODS:** A probabilistic sensitivity analysis was made in order to analyze results previously reported in which a deterministic sensitivity analysis was performed to study the cost-effectiveness of three OHA's: metformin, glibenclamide and acarbose. We used TreeAge-Pro® software for programming and simulating a Markov model of two health states (HbA_{1C}≤7% or HbA_{1C}>7%) and twelve cycles of 1 month for a time horizon of 1 year. The parameters of monthly success probability as beta distributions and monthly costs as lognormal distributions of therapeutic alternatives were computed through a parametrization of data. Monte Carlo's simulations were computed for cohorts of 10,000 patients for each treatment option. **RESULTS:** The results of the Monte Carlo's simulations showed very close iterations clouds for metformin and glibenclamide showing evident dominance of both over acarbose. In the acceptability curve generated, for a willingness to pay (WTP) = 0 the probabilities to be cost-effective were 49.46 %, 43.04 % and 7.50 % for glibenclamide, metformine and acarbose, respectively, whereas for a WTP = 1 mexican GDP per capita (US $ 7876.00 in 2009) were 66.26 %, 26.98 % and 6.76%. The glibenclamide versus metformin incremental cost-effectiveness analysis showed similar results as mentioned before, showing 59.72% of iterations below the WTP = 1 mexican GDP per capita line. **CONCLUSIONS:** The probabilistic sensitivity analysis showed which the initial drug therapy with glibenclamide or metformin have advantage over acarbose. There is not sufficient evidence to say glibenclamide has advantage over metformin for WTP near to cero, as in low to middle income countries where containment of expenditures is important.

PDB12

A HEALTH ECONOMIC ANALYSIS OF THE LONG-TERM OUTCOMES AND COSTS ASSOCIATED WITH USING CANAGLIFLOZIN VERSUS SITAGLIPTIN AS AN ADD-ON TO METFORMIN (MET) IN MEXICO

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OBJECTIVES: Canagliflozin (CANA) is a novel inhibitor of the sodium glucose co-transporter 2 in development for treating patients with type 2 diabetes mellitus (T2DM). In a previously reported randomized, double-blind, 4 arm parallel group (placebo, CANA 100mg, CANA 300mg and sitagliptin 100mg [SITA]) study of 1284 subjects inadequately controlled on MET monotherapy, CANA 100mg and 300mg significantly decreased HbA_{1c} versus placebo after 26 weeks of therapy by 0.62% and 0.77%, respectively; SITA decreased HbA_{1c}versus placebo by 0.65%. In this trial, both

CANA doses and SITA significantly reduced systolic blood pressure (CANA 100mg: 5.36 mmHg; CANA 300mg: 6.58 mmHg; SITA 3.34 mmHg), however, only CANA significantly reduced body weight (CANA 100mg: 2.5%; CANA 300mg: 2.9%) versus placebo. The objective of this study was to simulate the health outcomes and associated costs attributable to using CANA versus SITA in Mexico. **METHODS:** Forty-year outcomes associated with adding CANA 100mg or CANA 300mg versus SITA to MET were simulated using ECHO (Economic and Health Outcomes)-T2DM, a validated micro-simulation model. Treatment effects and patient characteristics were sourced from the trial. Simulated treatment was intensified when HbA_{1c} exceeded 7.5% by adding basal insulin, and subsequently prandial insulin. Disutilities associated with micro- and macro-vascular events were obtained from the literature and costs were adapted to the Mexican setting. **RESULTS:** Using CANA 300mg versus SITA was projected to reduce relative risks for key events (e.g. myocardial infarction 10.2%; congestive heart failure 6.6%; macroalbuminuria 6.6%; microalbuminuria 6.2%), improve QALYs (0.046), and result in lower costs per patient ($1927MXN). Simulation results of CANA 100mg versus SITA were generally similar, albeit estimates of reductions in relative risks, QALY gains and associated costs differences were smaller. **CONCLUSIONS:** These simulations suggest that using CANA versus SITA as an add-on to MET could result in improved outcomes and reduced costs in Mexico.

PDB13

ECONOMIC EVALUATION OF INSULIN LISPRO MIX 25 WITH GLARGINE IN THE TREATMENT OF TYPE 2 DIABETES MELLITUS PATIENTS IN THE MEXICAN PUBLIC HEALTH CARE SYSTEM IN MEXICO

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OBJECTIVES: Compare expected costs and health-outcomes in patients with Diabetes Mellitus Type 2 (DMT2) in the Public Sector in Mexico treated with glargine or 25%-insulin lispro, 75%-insulin lispro protamine suspension (LM25). **METHODS:** This analysis included a hypothetical cohort of insulin-naïve patients with T2DM, aged 30–80, years, with A1C>7.0% taking antihyperglycemic drugs for 90 days. Effectiveness measures included; (1) Percentage of patients with A1C<7.0% levels at 24 weeks, (2) frequency and type of micro and macrovascular complications (MMVC) and (3) hypoglycemic events per 1000 patients considering one-year timeframe. Costs evaluated were: 1) acquisition costs; 2) cost of hypoglycemic events; and 3) MMVC. Efficacy measures and mean-daily-dose was obtained from DURABLE, parallel, open-label and randomized study comparing directly LM25 and Glargine. Incidences of MMVC were estimated using data from UKPDS study group and data from Meta-analysis by Quayum following a similar process outlined by Grima. Acquisition costs were derived from the transparency portal of the Mexican Social Security Institute. Healthcare services utilization from hypoglycemic episodes were calculated according to international published literature and IMSS Unit Costs updated to 2013 following IMSS methodology, while other associated expenses with MMVC complications come from Mexican reports and Diagnostic Related Groups (DRG) published by IMSS this data was updated to January 2013 using the Bank of Mexico inflation calculator. Costs are expressed in 2013 USD (1USD=$12.70MXN) **RESULTS:** All results consider 1000 patients treated in a 1-yeat timeframe. Acquisition costs for LM25 were lower compared to glargine ($291,395 vs $383,521, 24% lower), although costs per hypoglycemia events were higher for LM25 ($12,242 vs. $3,673). Direct medical costs for MMVC were higher for Glargine ($668,027 vs. $754,435) Total medical costs were higher for glargine compared to LM25 ($971,663 vs. 1,141,628). **CONCLUSIONS:** Results of the present study suggest that compared with LM25, health care costs are significantly higher for glargine.

PDB14

HEALTH ECONOMIC BENEFITS OF SENSOR AUGMENTED INSULIN PUMP THERAPY IN COLOMBIA

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OBJECTIVES: To estimate the health economic impact of Sensor-Augmented Insulin Pump (SAP) Therapy among Insulin-Dependent Diabetes Mellitus (IDDM) patients in Colombia. **METHODS:** The Core Diabetes Model (CDM) is highly validated, computer simulation model to determine the long-term health outcomes and economic consequences of diabetes interventions. A recent real life clinical study in Colombia evaluating 217 IDDM patients (average baseline HbA1c of 8.97%, mean age 34 years, and average diabetes duration of 14 years) who initiated SAP therapy showed that SAP therapy led to a reduction of -1.47% HbA1c as well as a significant reduction in severe hypoglycaemic events. The impact of the reduction in the fear of hypoglycaemic events on quality of life was also included. **RESULTS:** Life expectancy of patients with SAP was increased by 3.51 years and diabetes related complications were delayed on average by 1.74 years. The Incremental-Cost-Effectiveness-Ratio (ICER) for SAP was $44,889,916COP ($24,939USD) per Quality-Adjusted-Life-Year gained based on direct costs only. SAP related therapy costs were partially offset by the savings due to the reduction in long-term complications, including proliferative diabetic retinopathy (PDR), Severe Vision Loss (SVL), End Stage Renal Disease (ESRD), and Amputations (AMP). The relative reduction in incidence of these complications (PDR 42%, SVL 20%, ESRD 46%, AMP 12%) as well as the average delay in their onset (4.9 years, 4.0 years, 3.8 years, 3.7 years, respectively) due to SAP therapy is profound. When including indirect costs, SAP demonstrated an even lower ICER. Extensive sensitivity analyses showed the robustness of the results. **CONCLUSIONS:** Using a payer's perspective, our analysis showed that SAP is cost-effective over a lifetime horizon in IDDM patients in the Colombian setting (using a WTP threshold of $60,771,600COP [3x GDP]) and can lead to an increase in life expectancy. When using a societal perspective, SAP was even more cost-effective.

PDB15

SHORT AND LONG-TERM COST-EFFECTIVENESS OF SWITCHING THERAPY FROM NPH INSULIN TO INSULIN DETEMIR IN PEOPLE WITH TYPE 2 DIABETES

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OBJECTIVES: To assess the cost-effectiveness (CE) of switching from NPH insulin ± oral glucose-lowering drugs (OGLDs) to insulin detemir ± OGLDs in people with type 2 diabetes (T2DM) in countries in different economic circumstances based on observational data gathered in routine clinical practice. **METHODS:** The A_1chieve® study assessed safety and outcomes over 24 weeks in 66,726 people with T2DM starting insulin analog therapy. Most people (96%) stated better glycemic control as reason to switching therapy, with 31% also stating hypoglycemia problems as a further reason. The CE analyses included data for people switching to detemir in South Korea (n=90) and in seven Arabian Gulf countries (n=124). Data were collected on clinical effectiveness and adverse events, and health-related quality of life using the EQ-5D questionnaire. CE analyses used the IMS CORE diabetes model with 1 and 30 year time horizons, with South Korea and Saudi Arabia country-specific costs for complications and therapies and background mortality rates. CE was measured by comparing outcomes at study-end with outcomes at pre-study. Incremental cost-effectiveness ratios (ICERs) are expressed as cost per QALY in local currencies, USD and in fractions of local GDP per capita. CE was pre-defined using the WHO definition of <3 times GDP per capita. **RESULTS:** 1-year ICERs were: South Korea (KWR 3,236,798; USD 2,980; GDP 0.13), and Saudi Arabia (SAR 27,221; USD 7,258; GDP 0.36). 30-year ICERs were: South Korea (KWR 872,589; USD 803; GDP 0.04), and Saudi Arabia (SAR 6,349; USD 1,693; GDP 0.08). Sensitivity analyses covering cost of self-monitoring, deterioration of glucose control with time, and other time horizons showed the results to be robust. **CONCLUSIONS:** Switching from NPH±OGLDs to detemir±OGLDs in people with T2DM as performed in the A_1chieve® study was found to be cost-effective in both country settings at 1 and 30 year time horizons.

PDB16

SHORT AND LONG-TERM COST-EFFECTIVENESS OF SWITCHING THERAPY FROM INSULIN GLARGINE TO INSULIN DETEMIR IN PEOPLE WITH TYPE 2 DIABETES

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OBJECTIVES: To assess the cost-effectiveness (CE) of switching from insulin glargine ± oral glucose-lowering drugs (OGLDs) to insulin detemir ± OGLDs in people with type 2 diabetes (T2DM) in Saudi Arabia, South Korea and Algeria based on observational data gathered in routine clinical practice. **METHODS:** The A_1chieve® study assessed safety and outcomes over 24 weeks in 66,726 people with T2DM starting insulin analog therapy. The CE analyses included people switching to detemir in Saudi Arabia (n=102), South Korea (n=82) and in 3 North-West African countries (n=94). Data were collected on clinical effectiveness and adverse events, and health-related quality of life using the EQ-5D questionnaire. CE analyses used the IMS CORE diabetes model with 1 and 30 year time horizons, with Saudi Arabia, South Korea and Algeria country-specific costs for complications and therapies and background mortality rates. Incremental cost-effectiveness ratios (ICERs) are expressed as cost per QALY in local currencies, USD and in fractions of local GDP per capita. CE was pre-defined using the WHO definition of <3 times GDP per capita. **RESULTS:** The switch was found to be less costly and have better outcomes in South Korea after 30 years and in Saudi Arabia at both time horizons. 1-year ICERs were: Saudi Arabia (SAR -5,849; USD -1,559; GDP -0.08), South Korea (KWR 296,842; USD 273; GDP 0.01), and Algeria (DZD 267,771; USD 3,363; GDP 0.80). 30-year ICERs were: Saudi Arabia (SAR -14,839; USD -3,957; GDP -0.19), South Korea (KWR -1,133,202; USD -1,043; GDP -0.05), and Algeria (DZD 226,818; USD 2,849; GDP 0.68). Sensitivity analyses on the 30 year time horizon showed the findings to be robust. **CONCLUSIONS:** Switching from glargine±OGLDs to detemir±OGLDs in T2DM as performed in the A_1chieve® study was found to be cost-effective across all country settings at 1 and 30 year time horizons.

PDB18

IMPACTO DE LA DIABETES SOBRE LA PRODUCTIVIDAD EN ARGENTINA

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OBJECTIVOS: Estimar y caracterizar el impacto de la enfermedad sobre la productividad laboral de personas con diabetes (DM) en Argentina. **METODOLOGÍAS:** Estudio descriptivo observacional relevando información mediante el cuestionario WPAI-GH (Work productivity and activity impairment - General Health version) en personas adultas (18 a 75 años) con DM, que concurrieron a su consulta habitual a dos centros asistenciales de La Plata. Los encuestados también respondieron sobre aspectos socioeconómicos y complicaciones de su enfermedad. La pérdida de productividad se estimó por el método del capital humano. Los resultados se presentan como media ± desvío estándar (DS) o proporciones. Para las comparaciones se utilizaron los test t de student, Kruskal-Wallis y Chi cuadrado, según correspondiera. Se consideró significativo p<0,05. **RESULTADOS:** Aceptaron participar en el estudio 73 personas con DM; 54,8% hombres con edad de 57 ± 15 años. El 42,5% poseía estudios superiores (nivel terciario o universitario completo). El 60,3% trabajaba, 6.4% estaba desempleado y el 33,3% inactivo (jubilado, pensionado). El tiempo promedio de trabajo fue de 43 ± 17 horas/semana y el 38% faltó/retiró de su trabajo por su enfermedad. El tiempo de trabajo perdido por ausentismo fue 9.1%, y por disminución de la productividad el 22%. La diabetes también disminuyó un 25% la capacidad para realizar actividades regulares diarias, afectando más a mujeres que a hombres (30 y 20,3%, respectivamente). La pérdida de productividad monetaria por ausentismo